National Diabetes Audit 2015–2016 shows variations in care processes and targets

The ‘V’ word is again prominent in the latest report on care processes and treatment targets from the National Diabetes Audit.1 As Steve Chaplin here reports, variation, unexplained by case mix, means that people in some parts of the country are being let down by their NHS.

What is the National Diabetes Audit?
The National Diabetes Audit (NDA) is one of 30 clinical audits conducted by the NHS (of which five are of some aspect of diabetes care); several new audits in other specialties are now being established, demonstrating the confidence of national agencies in the process. The NDA is commissioned by the Healthcare Quality Improvement Partnership, which is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. It is funded by NHS England and the Welsh Government with additional contributions for specific aspects from Scotland, Northern Ireland and the Channel Islands. It is prepared in collaboration with Diabetes UK and supported by Public Health England.

The purpose of the NDA is to help the NHS improve the quality of diabetes care in England and Wales. It provides the tools the NHS needs to assess local practice against the guidelines and quality standards published by NICE; to compare their services and outcomes with the results delivered by similar organisations elsewhere in the country; and to know what best practice is and be able to share it. This report comprises data generated from 1 January 2015 to 31 March 2016. For the first time, the NDA includes information about the care received by people with learning disabilities.

Last year’s report noted a drop in participation to only 57% of GP practices from nearly 71% in 2012/13. This was due to changes in the way data were collected from GPs. This year the figure is a much more encouraging 82% but, in 16 clinical commissioning groups (CCGs) across the country, fewer than 50% of practices took part, from Birmingham Cross City (15%) to Brent (30%) and South Tyneside (37%).

There are four components to the NDA:
- Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
- What percentage received the nine NICE key processes of diabetes care?
- What percentage achieved NICE defined treatment targets for glucose control, blood pressure (BP) and blood cholesterol?
- What are the rates of acute and long-term complications?

Registrations
Returns from GPs and specialist centres put the prevalence of diabetes in England and Wales at 6.4%, or 2.7 million people – this is equivalent to 8.3% of the population on the diabetes register recorded for the quality and outcomes framework (QOF) in England (100% in Wales). Public Health England estimates the figure for the over-16s in England is 8.7%. More men than women have type 1 diabetes (T1D) or type 2 (T2D) and other forms of diabetes. The distribution of ages differs as expected between T1D and
T2D but both suggest that, with increasing longevity, the number of people living with diabetes will increase substantially in the next 10–20 years.

What proportion received the care recommended by NICE?
All people with diabetes, aged 12 years and over, should receive all of the nine NICE recommended care processes annually and attend a structured education programme when they are diagnosed. Several of these processes are carried out as part of the cardiovascular risk assessment programme (BP, cholesterol, smoking, BMI), two are routine tests for renal function, and three are specific to diabetes. This means the additional workload associated with diabetes care is actually quite small. Retinal screening is the responsibility of NHS Diabetes Eye Screening, not GPs, and the report focuses on the other eight.

The proportion of people receiving all eight processes fell again in 2015/16, from 38.7% in 2014/15 to 36.5% for T1D, and from 58.7% to 53.7% for T2D and other types. This difference is largely due to the lingering impact of removing the urine albumin test from QOF; the proportion receiving other processes is more or less static. For all forms of diabetes combined, this proportion was below 30% for those aged 20–30, peaked at 55–60% between ages 65 and 80, then declined. Figure 1 shows the variation between CCGs in their delivery of each care process after adjustment for case mix (age, gender, ethnicity, duration of diabetes and social deprivation). It is remarkable that, in some CCGs or health boards, fewer than 60% of people with T1D are asked about smoking or have their BMI recorded. The fact that performance is better for people with T2D, who might receive these checks by virtue of older age, suggests that it may not be carrying out these processes that is the problem, but some aspect of delivering care to people with diabetes.

The recommendations drawn from these findings are necessarily high level. Commissioners should support services struggling to deliver good outcomes, and also trials of new approaches to care for younger people. Specialist and GP services need to benchmark their performance against their peers using both local and national data, choose a priority for improvement using the NDA Quality Improvement guides to identify opportunities, and implement improvement plans.

The proportion of people newly diagnosed with diabetes who are offered structured education has been increasing for several years and in 2014 had reached a modest 40% within one year for T1D and over 80% for T2D. The statistics suggest that these offers are ignored or considered unsuitable by most people, with fewer than 10% attending a course. The NDA says there are ‘good reasons’ to suspect these figures are not reliable and advises CCGs and education providers to improve their data recording. It points out that people with diabetes see a health care professional for 2–3 hours per year but have to manage their diabetes themselves for the remaining 8757 hours, and they need the knowledge and skills to do this.

Treatment targets
The NDA considers three treatment targets. These aren’t NICE targets – HbA1c is 6.5% in T1D patients and 7.0% in T2D patients on tablets/insulin, with no cholesterol target. They are more based on QOF and other guidelines.
- HbA1c ≤58mmol/mol (7.5%).
- Blood pressure ≤140/80mmHg.
- Cholesterol <5mmol/L.

These targets for glycaemic control and blood pressure reflect historical practice and are less ambitious than currently recommended by NICE; further, NICE does not recommend a target for lowering cholesterol.

The proportion of people with T1D who achieve all three targets has...
been dismally low for several years and in 2015/16 it got worse – 18.1% compared with 18.9% in the previous year. About twice as many people with T2D reached all their targets – 40.2% – but this was a 0.8-point drop compared with 2014/15. Achievement rates are low for people under 60 years of age and reach a (modest) plateau by the mid-70s.

Good glycaemic control remains the most difficult target to deliver. The BP target was reached by about 74% of people with T1D or T2D, and the cholesterol target by 71% and 77%, respectively. The figures for HbA1c were 29% and 66%, though it’s evident that more stringent targets for glycaemic control and cholesterol can be achieved by some people (Figure 2). The NDA describes the variation in performance between CCGs/local health boards, GPs and specialist services as ‘striking’. Most of this variation cannot be explained by patient demographics and the report highlights GP practices in Salford and Leicester, and the specialist centre at the Manchester Royal Infirmary, as good performers even though they serve a young population with a high proportion of women – both factors generally associated with poor target achievement. (These examples also have populations with high deprivation and a large ethnic mix but, surprisingly, neither of these is associated with low attainment.)

People with a learning disability

The NDA was commissioned by the Healthcare Quality Improvement Partnership to produce a supplementary report analysing the quality of care received by people with a learning disability. This coincides with the publication of the largest study of the health and care of people with learning disabilities in England, which reported much higher risks of long-term conditions in this population (including diabetes) and a substantial reduction in life expectancy – 18 years for women and 14 years for men.

Public Health England, which collaborated with NHS Digital to prepare the report, says it’s intended to help local health care commissioners and providers ‘to understand better the key health issues for this vulnerable group and how to tackle them more effectively’.

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<tr>
<th>Three core criteria:</th>
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<tr>
<td>• Lower intellectual ability (usually defined as an Intelligence Quotient [IQ] of less than 70)</td>
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<td>• Significant impairment of social or adaptive functioning</td>
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<td>• Onset in childhood</td>
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<th>The presence of:</th>
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<td>• A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with:</td>
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<td>• A reduced ability to cope independently (impaired social functioning)</td>
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Box 1. Criteria defining learning disability

Box 1 summarises the criteria used to define a learning disability. The NDA notes that ‘a person with a learning disability finds it harder than others to learn, understand and communicate,’ and people with multiple or profound disabilities need full-time help. The care provided to individuals who also have diabetes is therefore clearly a concern. According to QOF data, the proportion of people with diabetes who have a learning disability is higher than in the general practice population (0.65% vs 0.46%). This is equivalent to 17,078 people with diabetes who have a learning disability in England and Wales, of whom 1785 have T1D.

Overall quality of care is slightly better for people with T1D and a learning disability, of whom 41.7% receive all eight of the recommended care processes compared with 36.5% of the NDA population. The converse is true for T2D: 46.0% of people with a learning disability and 53.7% of the NDA population receive all processes. The differences are mostly of one or two percentage points for each process, though the gap is larger for BMI measurement (80.7% vs 75.2%) and smoking advice (82.8% vs 78.5%) for T1D; and (in the opposite direction) for foot surveillance (82.8% vs 86.7%) and particularly urine albumin (57.1% vs 66.7%) for T2D.

Learning disability makes no difference to the probability of being offered structured education, but the report provides no information about uptake of the courses because there aren’t enough data to analyse. This is surely a critical issue. Diabetes UK states: ‘Low literacy and comprehension levels can be a significant challenge when non-adherence with a treatment plan occurs. People with learning disabilities can gain more understanding and knowledge from interactive and participatory education models. An approach based on practice, participation and activity could be more effective than traditional health promotion material available for the general population.’

The charity has several easy-to-use factsheets and videos available on its website (www.diabetes.org.uk).

Consistent with better care delivery, people with a learning disability are more likely to achieve all three of the treatment targets and to gain any one of them. Glycaemic control is once more the challenge, with about one-third of people with T1D and two-thirds of those with T2D meeting the mark.

Summary

The NDA report shows that, in some respects, diabetes care edged forward in 2015/16. Given the turmoil generated by the NHS funding crisis, even this is a considerable achievement. With greater participation from GP practices, the latest analysis is more reliable than its predecessor but not much more heartening. Glycaemic control remains poor for many people with T1D and for young people generally. Services in some parts of the country are failing many patients and the majority of people with T1D still don’t receive all the recommended standards of care – none of which is exactly revolutionary. The position for T2D is better but still unsatisfactory. If there is a silver lining, it’s that people with learning disabilities are not disadvantaged in the care they receive but are actually doing somewhat better than the general population.

Steve Chaplin, BPharm, MSc, Medical Correspondent

References